STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Service
Prior Authorization Criteria

DUPIXENT® (dupilumab)
Effective 11/15/2018

Prior Authorization Request Form

DUPIXENT *is an interleukin-4 receptor alpha antagonist indicated:*

I. For the treatment of adult patients with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. DUPIXENT can be used with or without topical corticosteroids.

II. As an add-on maintenance treatment in patients with moderate-to-severe asthma aged 12 years and older with an eosinophilic phenotype or with oral corticosteroid dependent asthma.

I. For the Indication of Atopic Dermatitis, prior authorization requests may be approved if the following criteria are met:

1. Prescribed by or in consultation with an allergist, immunologist or dermatologist; **AND**
2. Documented diagnosis of moderate to severe Atopic Dermatitis (AD). Documentation must include the affected BSA, areas of involvement and severity of symptoms; **AND**
3. The patient must be within the age range as recommended by the FDA label and indication; **AND**
4. Affected body surface area is greater than or equal to 10%; **AND**
5. Patient has failed to find relief of symptoms after a minimum of 30-day trials of all agents from the following list in the last 12 months:
    a. Medium to High potency topical corticosteroid*
    b. Elidel
    c. Eucrisa
    d. Tacrolimus

*Requirement for topical corticosteroid therapy will be excluded for patients with sensitive areas of involvement such as the face, skin folds or genitals.

Initial approval of Dupixent for atopic dermatitis will be for 90 days. Additional therapy shall be approvable with documentation of satisfactory patient response (including current affected BSA and severity of symptoms).

II. For the indication of Asthma, prior authorization requests may be approved if the following criteria are met:

1. Prescribed by or in consultation with an allergist, immunologist or pulmonologist; **AND**

2. The patient must be within the age range as recommended by the FDA label and indication; AND

3. Patient must have documented adherence to a therapeutic regimen consisting of a LABA + high dose ICS therapy in the last 90 days; **AND EITHER**

4. Documentation must be supplied indicating a positive sputum test for eosinophilic phenotype asthma with eosinophils ≥ 150 cells/mcL; **OR** claims data must reflect a continual reliance on oral corticosteroid therapy in the last 90 days.

Initial approval of Dupixent for asthma will be for 90 days. Additional therapy shall be approvable with documentation of satisfactory patient response and compliance on inhaled therapy.

References

1.) LexiComp monograph for dupliumab (accessed 11/08/2018)
2.) Dupixent package insert revision 10/2018
3.) UpToDate literature review on the treatment of severe asthma in adolescents and adults (11/07/2018)
4.) UpToDate literature review on the treatment of atopic dermatitis (11/2018)
5.) https://www.aad.org/practicecenter/quality/clinical-guidelines/atopic-dermatitis/diagnosis-and-assessment/disease-severity-recommendations
6.) https://www.ecu.edu/cs-dhs/fammed/upload/Atopic-Dermatitis-Guidelines.pdf